IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 9, 2007

Kathleen Connerly, Administrator
Saint Joseph Transitional Care Unit
415 Sixth Street, P.O. Box 816
Lewiston, ID 83501

Provider #: 135121

Dear Ms. Connerly:

On February 12, 2007, a complaint investigation was conducted at St Joseph - Transitional Care Unit. The complaint investigation was conducted by Kari Head, R.D. and Lisa Kaiser, R.N. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00002579

ALLEGATION #1:

The complainant indicated that the resident had fallen and/or climbed out of bed and fractured her left hip because of a lack of adequate supervision by the facility. The complainant was worried that the resident had been receiving 1:1 supervision, but was not receiving it at this time.

FINDINGS:

The resident's record was reviewed and it was determined that the facility had made reasonable supervision accommodations. It was documented in the resident's record that the facility was checking on the resident every hour. The resident had been checked shortly before the fall and the tab alarm had been in place. At the time of the fall, the resident's tab alarm was not on the resident, however all staff interviewed indicated the alarm was on the resident the last time they had checked on her. The resident had not demonstrated increased confusion or attempts to self transfer prior to her fall and the facility's interventions had shown to be effective. The resident did get up unassisted and the pressure bed alarm had an unpredictable malfunction related to the special air overlay mattress that was recently placed on the bed. This type of malfunction had not been observed by the facility before when using an air overlay and a pressure pad alarm. The facility was not aware of this potential until after the resident fell. The resident fell and fractured

her hip, but the direct cause could not be attributed to the facility's lack of supervision of the resident.

After returning to the facility; 1:1 supervision of the resident was put in place at night while the facility was waiting for a special bed with pressure alarms and an air mattress to avoid the potential malfunction that occurred when the resident fell. Once the bed arrived, the resident did not need the 1:1 supervision at night. This was serving as a precautionary measure until the bed arrived. Staff was observed during the investigation survey to quickly answer bed and tab alarms when they sounded.

CONCLUSION:
Unsubstantiated. Lack of sufficient evidence

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Lorene Kayser

KARI HEAD, R.D.
Health Facility Surveyor
Long Term Care

KH/dmj